304 NCPDP

304.1 GENERAL INFORMATION

Introduction

Chapter 304 contains information on electronic Pharmacy transactions processing based on the National Council for Prescription Drugs Programs (NCPDP) Telecommunication Standard, Version 5, Release 1 (Real Time processing). This document will identify information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Illinois Department of Healthcare and Family Services (HFS).

Any questions regarding this chapter should be transmitted by email to hfswebmaster@illinois.gov

304.2 TRANSACTION TYPES

B1 – Billing
This is the basic format for transmission of a request for payment for a pharmacy service. Services submitted in this format must be identified using an NDC (National Drug Code). HCPCS (Health Care Financing Administration Common Procedure Coding System) codes and UPC (Universal Product Code) codes are not allowed. Please consult the appropriate Chapter 300 subchapter for a discussion of using the HIPAA 837 P (Professional) transaction to bill for non-drug items.

B2 – Billing Reversal
This format is used to reverse a previously paid claim. If the reversal is processed on the same day that the request for payment was processed, no record of the original service will be reported back to the Pharmacy. If the reversal is submitted on a day following the day of claim processing, then the pharmacy will see the paid claim and an offsetting adjustment for the claim. If the reversal is submitted after the claim has been reported on a Remittance Advice (HIPAA 835 transaction or HFS paper version), only the reversal adjustment will appear on the Remittance Advice.

B3 – Billing Rebill
This format is used to correct an error in a previously paid claim. It may not be used for a previously rejected claim. This format will cause the original claim to be reversed and the corrected claim information to be processed.

E1 – Eligibility Verification
This format may be used to determine an individual's HFS Medical Assistance Programs Eligibility status on the Date of Service. This same eligibility verification process is performed on each submitted claim.

N1 - Information Reporting
This format is used to collect information related to clinical and professional services unrelated to a dispensing event. The Department will capture, but not return, information submitted in this transaction.

N2 - Information Reporting Reversal
This format is used to reverse an N1 (Information Reporting) format. The Department will capture, but not return, data contained in this transaction.

N3 - Information Reporting Rebill
This format is used to reverse an N1 transaction and also send a corrected N1 transaction in the same transmission. The Department will capture, but not return, data contained in this transaction.

P1 - Prior Approval Request and Billing
This format is used to request a Prior Approval and submit a claim billing in the same transaction. Due to the need for Professional review of each Prior Approval, the Department will accept the Prior Approval request for review, but will not accept the claim billing portion of the transaction. The B1 transaction should be used to submit the claim once the Prior Approval request has been approved. For non-NDC codes please see the HIPAA X12 278 (Prior Authorization) transaction.

P2 – Prior Approval Reversal
This format is used to withdraw a request for Prior Approval due to either an error in the content of the request or the need for the prior approval no longer exists. This format may be used only until the Department has made a decision on the disposition of the Prior Approval. A Prior Approval can be reversed only while it is in "Captured" status (the HFS staff have begun an evaluation of the Prior Approval but have not reached a final decision). If the Prior Approval is marked as either "Approved" or "Denied", then a new Prior Approval with corrected information must be submitted. It will be necessary for the pharmacy to contact the Department to have the incorrect Prior Approval deleted from the system.

P3 – Prior Approval Inquiry
This format is used to check the status of a request for Prior Approval. If the Prior Approval has been received, but not been acted upon by HFS, the response returned will indicate "Captured". If the HFS staff have begun an evaluation of the Prior Approval, but have not reached a final decision, it will be marked as "Deferred". If the Prior Approval is marked as "Approved", then the claim should be submitted. If the Prior Approval is marked as "Denied" then the Department will indicate the reason for the denial.

P4 – Prior Approval Request Only
This format is used to submit a request for Prior Approval for a given NDC. This request is used whether the NDC is billed individually or as part of a Compound. For non-NDC codes please see the HIPAA X12 278 (Prior Authorization) transaction.

304.3 BUSINESS RULES

304.31 GENERAL BILLING

Pharmacies submitting claims electronically must conform to the standards of the NCPDP Version 5.1 Implementation Guide; the instructions set forth by the Department in this Electronic Handbook; the Department's Handbook for Pharmacy and any applicable notices, rules and laws.

NDCs will only be accepted in the 5-4-2 format.

Codes which are for Equipment and Supplies must be billed on the HIPAA 837P (Professional) transaction.

When a Billing Rebill transaction (B3) is used, the Provider Number, Patient Number, Date of Service, Prescription Number and NDC code must remain the same. If any of these fields must be changed, then the original service must be reversed using the B2 transaction and the prescription billed as a separate B1 transaction.

The following fields must match a paid claim in order for it to be reversed on the Department's Claims processing system:

Provider Number
Patient Number
Prescription Number
Date of Service
National Drug Code

A claim reversed on the same day it is submitted for processing will not appear on the Remittance Advice, either electronic or paper. A claim reversed on a date subsequent to its submittal date will appear on a Remittance Advice as paid. There will be an adjustment on either the same or a later Remittance Advice detailing the claim void.

304.32 PAYOR SHEETS

The Department has developed Payor sheets for the use of programmers in creating software to generate pharmacy claims and other transactions for the Illinois Medical Assistance Program. These Payor sheets define the required fields and allowable values that may be used within each field. Copies of the Payor sheets may be found in Appendices 2 and 3 of this handbook.

304.33 PARTIAL FILLS

The Department will accept only one partial fill transaction per prescription. Additional partial transactions will be rejected.

Dispensing fees will only be paid on completed prescriptions.

When a partial fill prescription is submitted, it must have a completed prescription submitted, prior to the next refill.

When a partial fill prescription is dispensed, but the patient does not receive the remainder of the prescription, the pharmacy must void the partial fill prescription and bill the prescription as a completed prescription to receive the dispensing fee.

The same prescription number must be assigned to both the partial fill and completed prescriptions.

304.34 PRIOR APPROVALS

The Department will accept all Prior Approval transactions.

The Prior Approval process, as currently defined by the Department, will continue under both Version 1.1 (Batch) and Version 5.1 (Real Time). Prior Approval requests will be considered in accordance with HFS policy. The Department will make every effort to review and reach a decision on each request as rapidly as possible, without bypassing its professional responsibilities.

It is the pharmacy's responsibility to check the Department's system, using the P3 transaction, to determine whether a final decision has been made on their request. The pharmacy may speak to one of the Department's staff pharmacists regarding questions that arise about the denial of a Prior Approval.

When a Prior Approval is entered into the HFS system, it will have a Prior Approval Reference Number (PARN) assigned. The pharmacy will need to use the PARN to inquire on the status of the Prior Approval. The PARN will be returned to the pharmacy in the Prior Authorization Number – Assigned (498-PY) field.

The following format will be used when submitting information in the Prior Authorization Supporting Documentation field (498 PP) of the Prior Approval segment:

RTS prior approval indicator	x(01) 'Y' indicates RTS PA
Regular prior approval indicator	x(01) 'Y' indicates Regular PA
Brand name requested indicator	x(01) 'Y' brand name pricing PA
Quantity limit indicator	x(01) 'Y' Min and Max Quantity PA
Min quantity requested	9(05)

Max quantity requested	9(05)
Age limit indicator	x(01) 'Y' Age PA
Sex limit indicator	x(01) 'Y' Sex PA
Daily Dose limit indicator	x(01) 'Y' Daily dose PA
Medicare Part B indicator	X(01)
Diagnosis Description area	x(64)
Note area	x(40)

For Field 498-PP only, for all numeric fields, zero fill when not used. For all alphanumeric fields, either space fill or use ‘N’, when not used.

If the RTS (Refill-Too-Soon) prior approval indicator is set to 'Y', then all other prior approval indicator fields must contain either spaces or zeros, as appropriate. If the RTS prior approval indicator field is set to spaces, then at least one or any combination of the other fields, must have data entered.

If the Quantity limit indicator field is set to 'Y', then both the Minimum quantity requested and Maximum quantity requested must contain numeric values, greater than zero. If the Quantity Limit indicator is set to spaces, then both the Minimum quantity requested and the Maximum quantity requested fields must be zeros.

The Diagnosis Description area and Note area may be filled in for any type of Prior Approval.

The Diagnosis Code on the Clinical Segment of the Prior Approval Segment may be used in place of the Diagnosis Description.

Please note that once the Department has made a decision on a Prior Approval, the pharmacy may not reverse the Prior Approval. The pharmacy must contact the Department to have the Prior Approval reversed from the system.

304.35 COMPOUND DRUGS

A compound is defined as the combination of two or more drugs into a single entity. For the purposes of billing a compound to the Illinois Medical Assistance Program, a maximum of 25 ingredients may be included. If a compound is submitted to the Department with over the maximum of 25 components, the transaction will be rejected.

Any ingredient that would require Prior Approval, if billed as a stand alone NDC, will still require a Prior Approval, to be paid as an ingredient in the compound. As with claims for a single NDC, only ingredients identified as Rebateable NDCs will be paid.

The Department will edit each ingredient within the compound individually and will price each ingredient based on the quantity of the ingredient used in the compound.

If any ingredient is not payable, the compound will be rejected in total. The pharmacy will then be able to either: correct any error causing the rejection, remove the ingredient(s) causing the errors and resubmit the claim or resubmit the claim requesting that the Department price the compound, excluding the rejected ingredients.

The pharmacy may elect to include a Submission Clarification Code of 8 (Process Compound for Approved ingredients). The use of this code bypasses the reimbursement for non-covered drugs. In this way, the Department will be able to process and price all valid NDC values instead of rejecting the transmission and returning to the pharmacy for review and resubmission. Please note that not all error rejection codes will be overridden by the use of the "08" value.

304.4 TRANSACTION RESPONSES

304.41 TRANSMISSION REJECT RESPONSE

A transmission rejected response will be returned for all transaction types if the data fails the basic format edits as defined in the NCPDP Version 5.1 specifications or if fields on the Provider Payor Sheets, with an HFS status of "Required", are missing or invalid.

304.42 BILLING TRANSACTION RESPONSES (B1)

The NCPDP error message set is fixed based on HIPAA documentation requirements. In some situations, HFS reports back edits which are not covered by the Version 5.1 error message set. When this occurs, the Department will return NCPDP reject code 85 (Claim Not Processed). Along with the "85" reject code, a Department generated descriptive message, related to the "85" reject code, will be loaded to the Additional Message area (field 526-FQ).

Programmers should make provisions so that users can access the Additional Message field as needed.

Payable or Duplicate Response

If the transaction passes all HFS defined edits, a payable response is returned. If the transaction is a duplicate of a payable transaction previously submitted, a duplicate response is returned. See section 4.3.2 of the Telecommunication Standard Implementation Guide 5.1 for duplicate criteria. Duplicate responses are identical to payable responses with the exception of a "D" in the Transaction Response Status.

Rejected Response

If the transaction fails one or more HFS defined edits, a rejected response is returned. In addition to the NCPDP reject codes, a 40 byte descriptive message, defined by HFS for the reject error, will be returned in the Additional Message Area, for the first 5 errors.

304.43 REVERSAL TRANSACTION RESPONSES (B2)

Approved or Duplicate Response

If the transaction passes all HFS defined edits, an approved response is returned. Check the Additional Message Area for a message that describes how the reversal was handled by HFS. If the transaction is a duplicate of an approved transaction previously submitted, a duplicate response is returned. See section 4.3.2 of the Telecommunication Standard Implementation Guide 5.1 for duplicate criteria. Duplicate Reversal responses are identical to approved Reversal responses with the exception of an “S” in the Transaction Response Status.

Rejected Response

If the transaction fails one or more HFS defined edits, a rejected response is returned. In addition to the NCPDP reject codes, a 40 byte descriptive message, defined by HFS for the reject error, will be returned in the Additional Message Area, for the first 5 errors.

304.44 REBILL TRANSACTION RESPONSES (B3)

Payable or Duplicate Response

If the transaction passes all HFS defined edits, a payable response is returned. Check the Additional Message Area for a message that describes how the reversal part of the rebill was handled by HFS. If the transaction is a duplicate of an approved transaction previously submitted, a duplicate response is returned. (See section 4.3.2 of the Telecommunication Standard Implementation Guide 5.1 for duplicate criteria). Duplicate responses are identical to approved responses with the exception of a “D” in the Transaction Response Status.

Rejected Response

If the transaction fails one or more HFS defined edits for the reversal part of the rebill, a rejected response is returned indicating that the reversal and the rebilled claim were not processed. If the reversal is successful, but the claim fails one or more HFS defined edits, a rejected response is returned for the claim only. In addition to the NCPDP reject codes, a 40 byte descriptive message, defined by HFS

for the reject error, will be returned in the Additional Message Area, for the first 5 errors.

304.45 ELIGIBILITY VERIFICATION TRANSACTION RESPONSES (E1)

Approved Response

If the transaction passes all HFS defined edits, an approved response is returned. Check the Additional Message Area for HFS eligibility information. This is a 200 character free text area.

Rejected Response

If the transaction fails one or more HFS defined edits, a rejected response is returned. In addition to the NCPDP reject codes, a 40 byte descriptive message, defined by HFS for the reject error, will be returned in the Additional Message Area, for the first 5 errors.

304.46 INFORMATION REPORTING RESPONSES (N1) INFORMATION REPORTING REVERSAL RESPONSES (N2) INFORMATION REPORTING REBILL RESPONSES (N3)

"Captured" Response

If any of these transactions are received, HFS will return a "Captured" response. HFS will not edit any of the data submitted in these transactions.

304.47 PRIOR APPROVAL REQUEST AND BILLING RESPONSES (P1)

"Captured" or Duplicate Response

If the transaction passes all HFS defined edits, a "Captured" response is returned. Check the Additional Message Area for additional information. Note that the billing part of the transaction will not be processed and will need to be resubmitted after the provider has determined that the prior approval has been approved. If the prior approval request is a duplicate of a prior approval transaction previously submitted, a duplicate response is returned. (See section 4.3.2 of the Telecommunication Standard Implementation Guide 5.1 for duplicate criteria). Duplicate responses are identical to approved responses with the exception of an "Q" in the Transaction Response Status field.

Rejected Response

If the transaction fails one or more HFS defined edits, a rejected response is returned. In addition to the NCPDP reject codes, a 40 byte descriptive message, defined by HFS for the reject error, will be returned in the Additional Message Area, for the first 5 errors.

304.48 PRIOR APPROVAL REVERSAL RESPONSES (P2)

Approved or Duplicate Response

If the transaction passes all HFS defined edits, an approved response is returned. Check the Additional Message Area for a message that describes how the reversal was handled by HFS.

If the transaction is a duplicate of an approved transaction previously submitted, a duplicate response is returned. (See section 4.3.2 of the Telecommunication Standard Implementation Guide 5.1 for duplicate criteria). Duplicate responses are identical to approved responses with the exception of an “S” in the Transaction Response Status.

Rejected Response

If the transaction fails one or more HFS defined edits, a rejected response is returned. In addition to the NCPDP reject codes, a 40 byte descriptive message, defined by HFS for the reject error, will be returned in the Additional Message Area, for the first 5 errors.

304.49 PRIOR APPROVAL INQUIRY RESPONSES (P3)

“Captured” or Deferred Response

If the transaction passes all HFS defined edits, and no action has been taken on the approval request, a “Captured” response is returned. If the action taken indicates that there will be a delay in approval, a prior approval deferred response will be returned. Check the Additional Message Area for additional information.

Approved Response

If the transaction passes all HFS defined edits, and the action taken was to approve the request, an approved response is returned. Check the Additional Message Area for information related to the approval.

Denied Response

If the transaction passes all HFS defined edits, and the action taken was to deny the request, a rejected response is returned with a reject code of 3Y (Prior Authorization Denied).

Rejected Response

If the transaction fails one or more HFS defined edits, a rejected response is returned. In addition to the NCPDP reject codes, a 40 byte descriptive message, defined by HFS for the reject error, will be returned in the Additional Message Area, for the first 5 errors.

304.410 PRIOR APPROVAL REQUEST RESPONSES (P4)

"Captured" or Duplicate Response

If the transaction passes all HFS defined edits, a "Captured" response is returned. Check the Additional Message Area for additional information. If the transaction is a duplicate of an approved transaction previously submitted, a duplicate response is returned. (See section 4.3.2 of the Telecommunication Standard Implementation Guide 5.1 for duplicate criteria). Duplicate responses are identical to approved responses with the exception of a "Q" in the Transaction Response Status.

Rejected Response

If the transaction fails one or more HFS defined edits, a rejected response is returned. In addition to the NCPDP reject codes, a 40 byte descriptive message, defined by HFS for the reject error, will be returned in the Additional Message Area for the first 5 errors.

304. 5 THIRD PARTY LIABILITY

The pharmacy must show the disposition of each request for payment, to any other Payer, when submitting the claim to HFS. If multiple payments are received from a given payor for the same prescription, the payments should be combined and submitted as a composite.

Other Payer ID (340-7C) values will be found at Appendix 14 (Pharmacy Business Managers) or Appendix 9 (TPL Resource Code Directory). The Appendix 14 values are five digits and the Appendix 9 values are three digits. These appendices can be found on the Web site at http://www.hfs.illinois.gov/handbooks/chapter100.html

Payment Group

Other Payer Amount Paid Count (341-HB) must be a numeric value of “1”.
Other Payer Amount Paid Qualifier (342-HC) must = “08”
Other Payer Amount Paid (431-DV) must be either $0.00 or greater than $0.00. Negative values will not be accepted in this field.

Reject Group

Other Payer Reject Count (471-5E) must be a numeric value equal to the number of error codes sent.
Other Payer Reject Codes (472-6E) must be valid values from Appendix F of the Version 5.1 Implementation Guide.

TPL/COB Coding

Coding of the COB/Other Payments segment is dependent upon the value assigned to the Other Coverage Code (308-C8).

If the Other Coverage Code (308-C8) value =
00 (Not Specified)
01 (No Other Coverage)
Then there should be no Other Payments segment (AM05) in the transaction.

If the Other Coverage Code (308-C8) values =
02 (Other Coverage Exists – Payment Collected)
08 (Claim is billing for copay)
Then Other Payments Count (337-4C) must be a numeric value of 1, 2 or 3.
Other Payer Coverage Type (338-5C) must be a numeric value of 01, 02, 03 or 99.
Other Payer ID Qualifier (339-6C) must be 99.
Other Payer ID (340-7C) must be a valid value as defined above.
Other Payer Date (443-E8) must be in the CCYYMMDD format.
Payment Group where Other Payer Amount Paid is greater than $0.00.

If the Other Coverage Code (308-C8) values =
04 (Other Coverage exists-payment not collected)
Then Other Payments Count (337-4C) must be a numeric value of 1, 2 or 3.
Other Payer Coverage Type (338-5C) must be a numeric value of 01, 02, 03 or 99
Other Payer ID Qualifier (339-6C) must be 99.
Other Payer ID (340-7C) must be a valid value as defined above.
Other Payer Date (443-E8) must be in the CCYYMMDD format.
EITHER
Payment Group is not sent
OR

Payment Group where Other Payer Amount Paid must be = $0.00.

If the Other Coverage Code (308-C8) values =
03 (Other Coverage exists-claim not covered)
05 (Managed Care plan denial)
06 (Other Coverage denied-not participating provider)
07 (Other Coverage exists- not in effect on DOS)
Then Other Payments Count (337-4C) must be a numeric value of 1, 2 or 3.
Other Payer Coverage Type (338-5C) must be a numeric value of 01, 02, 03 or 99.
Other Payer ID Qualifier (339-6C) must be 99.
Other Payer ID (340-7C) must be a valid value as defined above.
Other Payer Date (443-E8) must be in the CCYYMMDD format
Reject Group

NOTES

If the pharmacy is unable to identify a valid Other Payer value from either Appendix 9 or Appendix 14, the Other Payer ID field should be “999”. If the pharmacy wishes to combine several payers into one composite entry
Then Other Payments Count (337-4C) must be a numeric value of 1.
Other Payer Coverage Type (338-5C) must be a numeric value of 99.
EITHER
Other Payer ID Qualifier (339-6C) is not sent.
Other Payer ID (340-7C) is not sent.
OR
Other Payer ID Qualifier (339-6C) must be 99
Other Payer ID (340-7C) is “999” or spaces
AND
Other Payer Date (443-E8) must be in the CCYYMMDD format.
Either the Payment Group or the Reject Group will be submitted based on Other Coverage Code (308-C8) rules described above.

If the Patient has both Medicare and Medicaid coverage, bill Medicare only. The Medicare processor will automatically crossover any paid claims to HFS. If Medicare rejects the claim, then the pharmacy must bill the claim to HFS showing the appropriate coding. If the Patient has both Medicare and Senior Care coverage, the pharmacy must bill Medicare first. After Medicare has adjudicated the claim, then the pharmacy must bill the claim to HFS showing the appropriate coding.

304.6 TOPIC REMOVED